Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective December 15, 2025 (unless otherwise noted)

Note – Log-in is needed for policy update sections marked with an asterisk *. Use this link to log-in, Cigna for Health Care Professionals > Resources > Reimbursement and Payment Policies.

Medical Coverage Policy	New, Updated, or Retired?	Comments
Diabetes Equipment and Supplies - (0106)	Updated	Important **changes** in coverage criteria: • added Simplera CGM to existing therapeutic/non-adjunctive continuous glucose monitoring system coverage policy statement.
Intensive Behavioral Interventions - (EN0499)	Updated	Minor **changes** in coverage criteria/policy: • No true changes in coverage, lots of wordsmithing & reformatting in the policy statement section.
Intestinal and Multivisceral	Updated	Posting 12/15/2025, effective date 3/15/2026

Transplantation - (0288)		Important **changes** in coverage criteria: • Added policy statements if individual has a history of malignancy • Added policy statement for non-coverage of living-donor intestinal transplantation.
Laboratory Testing for Transplantation Rejection - (0465)	Updated	Important **changes** in coverage criteria: • Added example of HepatoTrack™ to other gene expression profiling tests • Added example of OmniGraf® Liver to donor-derived cell-free DNA testing • Removed examples VitaGraftTM Kidney Baseline + 1st Plasma Test, VitaGraftTM Kidney Subsequent from donor-derived cell-free DNA testing.
Stem Cell Transplantation: Blood Cancers - (0533)	Updated	Posting 9/15/2025; Effective 12/15/2025. Important **changes** in coverage criteria: • Revised the policy statement for non-Hodgkin lymphoma by adding a separate not medically necessary policy statement for autologous hematopoietic stem cell transplantation (HSCT) in an adult with mycosis fungoides and Sézary syndrome to align with professional societies. • Revised the autologous HSCT policy statement for primary central nervous system lymphoma to include first remission as part of consolidation therapy.
Surgical Treatments for Obstructive Sleep Apnea - (0158)	Updated	Posting 12/15/2025, Effective date 3/15/2026 Important **changes** in coverage criteria: • Revised policy statement for drug-induced sleep endoscopy (DISE) in adults, removing the requirement that a mandibular repositioning appliance or tongue-retaining appliance be considered and found to be ineffective or undesirable prior to DISE, making this procedure less restrictive. • Revised policy statement for uvulectomy from experimental, investigational or unproven to not medically necessary. • Revised policy statement for implantable upper airway hypoglossal nerve stimulation devices in adults to add the U.S. Food & Drug Administration (FDA)-approved, device-specific indications related to age and apnea-hypopnea index on polysomnography. • Removed policy statement for tongue implant (e.g., ReVENT® Sleep Apnea System), as this technology is not FDA-approved and does not appear to be under active clinical investigation.
Transcatheter Heart Valve Procedures - (0501)	Updated	Minor **changes** in coverage criteria/policy: • Revised policy statement for:

		• Transcatheter aortic valve-in valve implantation-Removed specific device names from policy statement • Medtronic Melody Transcatheter Pulmonary Valve-updated to include surgical bioprosthetic pulmonary valve • Transcatheter mitral valve-in-valve implantations-Removed specific device names from policy statement • Percutaneous tricuspid valve repair and replacement- Added device examples
Transvaginal Ultrasound, Non-Obstetrical - (0398)	Updated	Posting 12/15/2025; Effective 03/15/2026. Important **changes** in coverage criteria: • Removed policy statement regarding screening or surveillance of a woman at increased risk for ovarian or endometrial cancer to align with current recommendations by professional societies. • Revised policy statement regarding screening for cancer for clarity and consistency in policy statements.
Vagus Nerve Stimulation (VNS) - (0350)	Updated	Posting/Effective 12/15/2025. Minor **changes** in coverage criteria/policy: • Revised policy statement for "other" not medically necessary indications regarding depression and rehabilitation therapy for chronic ischemic stroke. • Removed unmanaged codes and the policy statements associated with those codes.
Ventricular Assist Devices (VADs), Percutaneous Cardiac Support Systems and Total Artificial Heart - (0054)	Updated	Minor **changes** in coverage criteria/policy: • Revised multiple policy statements to improve formatting, readability, and clarity without change to policy position. • Revised policy statement for a percutaneous VAD (pVAD) used for any other indication by adding "off-label use as a long-term alternative to implantable VADs" to the existing not medically necessary statement.
Autism Spectrum Disorders/Pervasive Developmental Disorders: Assessment and Treatment - (0447)	Updated	• No change in coverage.

Cardiac Resynchronization Therapy (CRT) - (0174)	Updated	• No change in coverage.
High Intensity Focused Ultrasound (HIFU) - (0274)	Updated	• No change in coverage.
Prescription Digital Therapeutics - (0565)	Updated	• No change in coverage.
Serum Folate and Red Blood Cell Folate Testing - (0567)	Updated	• No change in coverage.
Stem Cell Therapy for Orthopaedic Applications - (0552)	Updated	• No change in coverage.
Temporomandibular Joint (TMJ) Disorder Surgery - (0156)	Updated	• No change in coverage.
Tilt Table Testing - (0270)	Updated	• No change in coverage.
Wide-Area Transepithelial Tissue Sampling with Computer-Assisted 3D Analysis (WATS3D) - (0578)	Updated	• No change in coverage.
Attention Deficit/Hyperactivity Disorder (ADHD): Assessment and Treatment (CP 0231)	Retired	• This CP is retired because the codes are either directly addressed by other CPs or are implemented via benefit classing.

ASH Guidelines	New, Updated, or Retired?	Comments
Chiropractic Care - (CPG278)	Updated	• No change in coverage.
Occupational Therapy - (CPG155)	Updated	• No change in coverage.
Physical Therapy - (CPG135)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Guidelines	New / Updated	Posted **8/20/2025**; Effective **12/1/2025** New guideline: • Management of Unlisted Codes Posted **11/19/2025**; Effective **2/3/2026** Two informational documents were updated with no clinically impactful changes: • CMS Policy Hierarchies and Application Guidelines • Guideline Definitions
Cobranded Cigna-EviCore Gastrointestinal Endoscopic Procedure Guidelinesv	Updated	Posted **12/1/2025**; Effective **5/1/2026** Important **changes** in coverage criteria. One guideline was updated with clinical changes which will expand and limit coverage: Esophagogastroduodenoscopy (EGD)

Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	Posted **9/2/2025**; Effective **12/1/2025**
		
		Important **changes** in coverage criteria.
		
		• Numerous clinical changes throughout will expand and limit coverage:
		  ○ Oncology Imaging
		
		Posted **9/19/2025**; Effective **12/1/2025**
		
		Important **changes** in coverage criteria.
		
		• One guideline was updated with clinical changes which will expand coverage:
		  ○ Breast Imaging

Cobranded Cigna-EviCore Lab Management Guidelines	New	Posted **12/1/2025**; Effective **4/10/2026** Six new guidelines: • APOE Variant Analysis for Alzheimer Disease Testing • Duchenne and Becker Muscular Dystrophy Testing • Multiple Endocrine Neoplasia Type 1 Genetic Testing • Multiple Endocrine Neoplasia Type 2 Genetic Testing • Peutz-Jeghers Syndrome Genetic Testing • Von Hippel-Lindau Disease Genetic Testing
Cobranded Cigna-EviCore Musculoskeletal Management Guidelines	New / Updatde	Posted **9/19/2025**; Effective **12/18/2025** The following guidelines were updated with no clinically impactful changes: • CMM-208: Ablations/Denervations of Facet Joints and Peripheral Nerves • CMM-308: Intradiscal Procedures • CMM-612: Grafts • CMM-615: Electrical and Low Frequency Ultrasound Bone Growth Stimulation (Spine) • Preface to the Comprehensive Musculoskeletal Management (CMM) Guidelines Posted **11/18/2025**; Effective **12/18/2025**

		Important **changes** in coverage criteria.
		
		• One guideline was updated with a clinical change which will expand coverage:
		  ○ CMM-609: Lumbar Fusion (Arthrodesis)
		
		Posted **11/21/2025**, Effective **3/7/2026**:
		
		Important **changes** in coverage criteria.
		
		• Three guidelines were updated with clinical changes which will limit coverage:
		  ○ CMM-311: Knee Replacement/Arthroplasty
		  ○ CMM-313: Hip Replacement/Arthroplasty
		  ○ CMM-315: Shoulder Surgery-Arthroscopic and Open Procedures
		
		• Three guidelines were updated with no clinically impactful changes:
		  ○ CMM-312: Knee Surgery - Arthroscopic and Open Procedures
		  ○ CMM-314: Hip Surgery - Arthroscopic and Open Procedures
		  ○ CMM-318: Shoulder Arthroplasty/Replacement/Resurfacing/Revision/Arthrodesis
		
		Posted **11/24/2025**; Effective **3/7/2026**
		
		New guideline:
		CMM-310: Manipulation of the Spine Under Anesthesia

Cobranded Cigna-EviCore Radiation Oncology Guidelinesv	Updated	Posted **11/18/2025**; Effective **1/1/2026** Guidelines were updated with no clinically impactful changes.
Administrative Policy	**New, Updated, or Retired?**	**Comments**

		• No updates in December 2025
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Allergen Immunotherapy – Grass Pollen Sublingual Products - (IP0515)	Updated	Effective 12/15/2025 **Conditions Not Covered:** **Updated** the concurrent use statement. Palforzia (peanut [*Arachis hypogaea*] allergen powder-dnfp for oral administration) was added as an example of allergen immunotherapy.
Allergen Immunotherapy – Odactra - (IP0516)	Updated	Effective 12/15/2025 Policy title updated from "Odactra" to "Allergen Immunotherapy – Odactra". **Added** a policy statement. **Updated** the diagnostic requirement. **Removed** the prerequisite step through an intranasal corticosteroid therapy or an oral or intranasal antihistamine. **Removed** the Reauthorization Criteria and Authorization Duration sections. **Conditions Not Covered:** **Updated** the concurrent use statement. Palforzia (peanut [*Arachis hypogaea*] allergen powder-dnfp for oral administration) was added as an example of allergen immunotherapy.
Allergen Immunotherapy – Ragwitek - (IP0518)	Updated	Effective 12/15/2025 Policy title updated from "Ragwitek" to "Allergen Immunotherapy – Ragwitek". **Added** a policy statement. **Updated** the diagnostic requirement. **Removed** the prerequisite step through an intranasal corticosteroid therapy or an oral or intranasal antihistamine. **Conditions Not Covered:** **Updated** the concurrent use statement. Palforzia (peanut [*Arachis hypogaea*] allergen powder-dnfp for oral administration) was added as an example of allergen immunotherapy.

Antibiotics (Inhaled) – Arikayce Prior Authorization Policy - (IP0383)	Updated	Effective: 12/15/2025 **Updated** policy title from "Amikacin Lipsome" to "Antibiotics (Inhaled) – Arikayce Prior Authorization Policy."
Anticoagulants – Dabigatran - (IP0033)	Updated	Effective: 12/15/2025 **Updated** *preferred product* criteria for Pradaxa (brand) capsules and pellets.
Antiseizure Medications – Nayzilam - (IP0338)	Updated	Effective: 12/1/2025 **Policy Title:** **Updated** from "Midazolam Nasal Spray" to "Antiseizure Medications – Nayzilam". **Removed** age requirement from the criteria. **Removed** requirement "documentation of use for the acute treatment of seizure activity" from the criteria. **Removed** requirements for documentation from the criteria. **Removed** Reauthorization Criteria from the criteria. In the criteria, reference to antiepileptic medications was changed to antiseizure medications.
Bone Modifiers – Denosumab Products (Prolia) - (IP0331)	Updated	Effective 12/15/2025 Conexxence was added to the policy with the same criteria as the other denosumab (Prolia, biosimilars) products. **Bone Loss (Treatment to Increase Bone Mass) in Patients with Nonmetastatic Prostate Cancer at High Risk for Fracture Receiving Androgen Deprivation Therapy:** Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion) Firmagon (degarelix subcutaneous injection), Orgovyx (relugolix tablets) were added as examples of androgen deprivation therapy. **Glucocorticoid-Induced Osteoporosis – Treatment:** Binosto (alendronate effervescent tablets for oral solution) added as an example of a bisphosphonate. **Osteoporosis Treatment for a Postmenopausal Patient:** Binosto (alendronate effervescent tablets for oral solution) added as an example of a bisphosphonate.

		Osteoporosis Treatment (to Increase Bone Mass) for Men: Binosto (alendronate effervescent tablets for oral solution) added as an example of a bisphosphonate. **Treatment of Bone Loss in Patients with Prostate Cancer Receiving Androgen Deprivation Therapy:** Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion) and Firmagon (degarelix subcutaneous injection) were added as examples of androgen deprivation therapy. **Conditions Not Recommended for Approval:** For Concurrent Use with Other Medications for Osteoporosis, the Note was modified from "this does NOT exclude use of calcium and/or vitamin D supplements in combination with denosumab products (Prolia, biosimilars)" to "calcium and/or vitamin D supplements may be used in combination with this medication." **Added** preferred product requirements for Conexxence and Stoboclo for both Employer Plans and Individual and Family Plans. **Coding Information:** **Added** HCPCS codes: Q5136, Q5157, Q5158
Bone Modifiers – Denosumab Products (Xgeva) - (IP0332)	Updated	Effective 12/15/2025 Bomyntra was added to the policy with the same criteria as the other denosumab (Xgeva, biosimilars) products. **Updated** the policy statement. **Preferred Product Criteria Table for Employer and Individual and Family plans.** **Added** preferred product requirements for Bomyntra. **Updated** preferred product requirements for Osenvelt. **Updated** preferred product requirements for Wyost and Xgeva. **Coding Information:** **Added** HCPCS codes: Q5157, Q5158 **Removed** HCPCS codes: C9399, J3490, J3590
Brands with Bioequivalent Generics - (IP0011)	Updated	Effective 12/01/2025 **Added** for Employer Plans: Ambien, Ambien CR, Restoril **Added** for Individual and Family Plans: Ambien, Ambien CR, Lunesta, Renvela tablet, Restoril, Rozerem
Colony Stimulating Factors – Ryzneuta - (IP0745)	Updated	Effective: 12/1/2025 **Employer Plans** **Added** Rolvedon and one pegfilgrastim product step requirements.

		Individual and Family Plans Preferred Product Criteria Tables **Added** one pegfilgrastim product step requirements.
Complement Inhibitors - Veopoz - (IP0587)	Updated	Effective: 12/1/2025 **Updated** policy title **from** "Pozelimab-bbfj" **to** "Complement Inhibitors – Veopoz." **CD55-Deficient Protein-Losing Enteropathy (CHAPLE Disease [Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy]):** The following requirements were removed that the patient has received or is in compliance with updated meningococcal vaccinations according to the most current Advisory Committee on Immunization Practices recommendations and that the patient has received or is in compliance with updated vaccinations for the prevention of Streptococcus pneumonia and Haemophilus influenza type b infections according to the most current Advisory Committee on Immunization Practices guidelines. For initial therapy and for a patient currently receiving Veopoz, the phrase "pathogenic variant" replaced "mutation". **Added [documentation required]** to the following criterion "Patient has a serum albumin level ≤ 3.2 g/dL." **Added** criteria for "Patient Currently Receiving Veopoz."
Compounded Medications - (IP0251)	Updated	Effective 12/15/2025 **Added** documentation statement **Updated from** "There is documentation the individual has had an inadequate response, contraindication, or is intolerant to ALL FDA-approved commercially available pharmaceutical alternatives that require a prescription, and approved for the same route of administration." **to** "The patient has experienced inadequate efficacy, significant intolerance, or has a contraindication to ALL (up to five) FDA-approved commercially available pharmaceutical alternatives that require a prescription, and approved for the same route of administration [documentation required]" **Updated from** "Support from results of at least two different controlled clinical studies published in peer-reviewed English language, biomedical journals or appropriate compendia, American Hospital Formulary Service (AHFS) **to** "Use is supported by standard medical reference compendia (for example: Clinical Pharmacology, MicroMedex, Wolters Kluwer Facts and Comparisons) and is not contraindicated or otherwise not recommended in the FDA product information (Label) or compendia"

		Updated Conditions Not Covered
Contraceptives - (IP0036)	Updated	Effective: 12/15/2025 Removed Generess, Minastrin 24 FE, Mircette, 28 Day, Quartette, Seasonique from coverage policy (discontinued products). Employer Plans Preferred Product Table: Added Averi. Individual and Family Plans Preferred Product Table: Added Annovera, Depo-Provera SubQ 104, Nexplanon with criteria effective until 12/31/2025. Removed Generess FE, Layolis FE, Natazia, Slynd. Removed effective 1/1/2026 Annovera, Depo-Provera SubQ 104, Femlyv, Nexplanon, Nextstellis, Phexxi, Twirla.
Crysvita - (IP0285)	Updated	Effective: 12/1/2025 **Policy Title:** **Updated** from "Burosumab" to "Crysvita" **Tumor-Induced Osteomalacia. [documentation required]** added to indication. **X-Linked Hypophosphatemia:** Criteria for a patient ≥ 18 years of age were updated to approve if the patient has fractures and/or pseudofractures OR if according to the prescriber, the patient is currently exhibiting one or more signs or symptoms of X-linked hypophosphatemia and has either tried oral phosphate and calcitriol therapy or has a contraindication to oral phosphate therapy, calcitriol therapy, or both, according to the prescriber. Previously, criteria required a patient who had fractures and/or pseudofractures to have either tried oral phosphate and calcitriol therapy or has a contraindication to oral phosphate therapy, calcitriol therapy according to the prescriber. Examples of signs and symptoms of X-linked hypophosphatemia in patients ≥ 18 years of age were updated to remove fractures/pseudofractures (captured in other criteria) and add stiffness and biochemical and/or clinical signs of osteomalacia. Throughout criteria, "Per the prescriber" was changed to "According to the prescriber".
Dermatology – Filsuvez - (IP0635)	Updated	Effective: 12/1/2025

		Dystrophic Epidermolysis Bullosa: The approval duration for both initial therapy and patient is currently receiving Filsuvez on previously treated wound(s) was modified to 12 months. Previously the approval duration was 3 months. The approval option "squamous cell carcinoma has been considered for the target wound(s)" was modified to "the prescriber attests that there is no evidence or clinical suspicion of squamous cell carcinoma at the target wound(s)".
Dermatology – Gene Therapy – Zevaskyn - (IP0747)	Updated	Effective 12/15/25 Coding Information **Added** HCPCS: J3389 with a note "Code effective 1/1/2026" **Updated** the description for C9399, J3490 & J3590 to include the note "Code effective until 12/31/2025"
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	Effective: 12/1/2025 **Added preferred product step requirement for the following products:** Seysara, Khindivi, Micort HC 2.5 % rectal cream (effective 12/15/2025), insulin aspart protamine/insulin aspart, Flexpen and vial (authorized generic of Novolog Mix 70/30), Kirsty and Kirsty Pen, Merilog and Merilog SoloStar, Femring, Imvexxy, Gloperba, Zelsuvmi, Yupelri, Belsomra, Edluar, zolpidem 7.5 mg capsules (brand), Quviviq, Osphena, sertraline 150 mg and 200 mg capsules, and Fetzima (effective 1/1/2026). **Updated preferred product step requirement for the following products:** Carac, Klisyri, Aplenzin, Auvelity (effective 1/1/2026), Cleocin Vaginal Ovules, Clindesse vaginal cream, Nuvessa, Xaciato, Conjupri, levamlodipine tablets, Novolin 70/30 FlexPen and vials, Novolin N FlexPen and vials, Novolin R Flexpen and vials, Novolog 70/30 FlexPen and vials, Admelog and Admelog SoloStar, Apidra and Apidra SoloStar, Fiasp and Fiasp PumpCart, insulin aspart (authorized generic for NovoLog), NovoLog, Estring, and Armour Thyroid. **Removed** preferred product requirements for Adthyza
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	Effective: 12/15/2025 **Added preferred product step requirement for the following products:** Norgesic, Norgesic Forte, orphenadrine/aspirin/ caffeine 25-385-30 mg tablets (generic for Norgesic), orphenadrine/aspirin/caffeine 50-770-60 mg tablet (generic for Norgesic Forte), Orphengesic Forte, Motegrity, Analpram-HC lotion, gabapentin extended-release tablets (generic for Gralise), Gralise, Horizant, dicyclomine 40 mg tablets, Glycopyrrolate

		Enfit, Amrix, chlorzoxazone 250 mg, 375 mg, and 750 mg tablet. Lorzone, methocarbamol 1000 mg tablet, baclofen 5 mg/5 mL oral solution (generic for Ozobax), baclofen 10 mg/5 mL oral solution (generic for Ozobax DS), baclofen oral suspension, concentrated formulation 25 mg/5mL (generic for Fleqsuvy), Fleqsuvy, Lyvispah, Ozobax, and Ozobax DS.
Enzyme Replacement Therapy-Xenpozyme - (IP0500)	Updated	Effective: 12/1/2025 **Policy Title:** **Updated** from "Olipudase alfa-rpcp" to "Enzyme Replacement Therapy-Xenpozyme". **Updated** policy template. **Removed** "documented" language throughout coverage policy criteria and replaced with bracketed *documentation required* after applicable criteria. **Updated** diagnostic criteria to require enzymatic assay testing and to screen a diagnosis of Gaucher disease ruled out.
Hematology - Aphexda - (IP0597)	Updated	Effective: 12/1/2025 **Policy Title.** **Updated from** "Motixafortide" **to** "Hematology – Aphexda" **Multiple Myeloma.** **Added "**Note: Examples of filgrastim products include Granix (tbo-filgrastim subcutaneous injection) and Neupogen (filgrastim subcutaneous injection and intravenous infusion), as well as related biosimilars." **Preferred Product Table.** **Updated from** "Failure, Contraindication, or Intolerance to plerixafor injection" **to** "Approve if the patient has tried plerixafor injection"
Hematology - Vonvendi - (IP0555)	Updated	Effective: 12/15/2025 ○ **Von Willebrand Disease:** Removed age restriction.
Hepatology - Givlaari - (IP0118)	Updated	Effective: 12/15/2025 **Policy Title**

		Updated from "Givosiran" **to** "Hepatology – Givlaari" **Added** documentation statement and documentation requirements throughout the policy. **Acute Hepatic Porphyria** **Updated** initial approval duration **from** 6 months **to** 1 year **Updated from** "(for example neurovisceral symptoms, blistering lesions, hepatic involvement, peripheral neuropathy, abdominal pain, constipation, muscle weakness, pain in the arms and legs) **to** "Note: examples of clinical features associated with acute intermittent porphyria include neurovisceral symptoms, blistering lesions, hepatic involvement, peripheral neuropathy, abdominal pain, constipation, muscle weakness, and pain in the arms and legs." **Updated from** "Elevated urinary or plasma porphobilinogen (PBG) greater than the upper limit of normal" **to** "Elevated urinary porphobilinogen (PBG) greater than the upper limit of normal" **Updated from** "Prior to starting treatment with givosiran (Givlaari), the individual has a history of one porphyria attack in the last 6 months that required a hospitalization, urgent healthcare visit, or intravenous hemin administration " **to** "Prior to starting treatment with Givlaari, the patient has a history of one porphyria attack in the last 6 months that required a hospitalization, urgent healthcare visit, or intravenous hemin administration at home" **Removed** medical geneticist from specialty requirement. **Removed** reauthorization criteria.
Hereditary Angioedema – Ekterly Drug Quantity Management Policy – Per Days for Individual and Family Plans - (DQM010)	New	Effective 12/1/2025 New policy
Homozygous Familial Hypercholesterolemia – Evkeeza - (IP0128)	Updated	Effective: 12/01/2025 **Homozygous Familial Hypercholesterolemia**: For Initial Criteria, the criteria were divided based on age as follows: ≥ 10 years of age and 1 year to < 10 years of age. Previously, all

		patients ≥ 5 years of age were required to try one high-intensity statin along with ezetimibe for 8 continuous weeks (and have an LDL-C ≥ 70 mg/dL) or be statin intolerant; these requirements were removed for the new group of patients who are 1 year to < 10 years of age. Also, the criterion that allowed an exception for the requirement to try one proprotein convertase subtilisin kexin type 9 inhibitor for a patient 5 years or 9 years of age was removed as it is no longer needed. A patient 1 year to < 10 years of age are no longer required to try previous therapies, but must meet the previously defined diagnostic criteria for homozygous familial hypercholesterolemia.
Infertility-Gondadotropin-Releasing Hormone (GnRH) Antagonists - (IP0333)	Updated	Effective: 12/1/2025 **Updated** policy title from "Gonadotropin-Releasing Hormone (GnRH) Antagonists for Infertility Use" to "Infertility – Gonadotropin-Releasing Hormone Antagonists". **Updated** Individual and Family Plans Preferred Product Criteria for brand Cetrotide.
Inflammatory Conditions – Tremfya Subcutaneous Drug Quantity Management Policy – Per Days - (DQM012)	New	Effective 12/1/2025 ○ New policy.
Inflammatory Conditions – Tocilizumab Intravenous Products Preferred Specialty Management Policy - (PSM012)	Updated	Effective 12/1/2025 Tofidence Non-preferred product criteria was updated to apply to all conditions/diagnoses, previously was applied only to Juvenile Idiopathic Arthritis and Rheumatoid Arthritis. Documentation requirements were added to the policy.
Inflammatory Conditions – Xeljanz/Xeljanz XR Prior Authorization Policy - (IP0692)	Updated	Effective 12/1/2025 **Psoriatic Arthritis:** Separated products approved based on age. Added an option of approval for Xeljanz immediate-release tablets and oral solution in a patient > 2 years of age. Specified approval of Xeljanz XR tablets is for a patient > 18 years of age.

Lidocaine Patch Products - (IP0709)	Updated	Effective: 12/15/2025 **Updated** policy title **from** "Ztlido for Individual and Family Plans" **to** "Lidocaine Patch Products." **Added** Lidoderm patches to policy. **Added** preferred product table **for** Employer Plans with criteria for Lidoderm patches. **Added** Lidoderm patches **to** preferred product table for Individual and Family Plans. **Osteoarthritis**: The note providing examples of different classes of pharmacologic therapies for osteoarthritis was updated to add duloxetine. It was also clarified that salicylates and celecoxib are examples of nonsteroidal anti-inflammatory drugs.
Metabolic Disorders – Betaine Anhydrous for Individual and Family Plans - (IP0465)	Updated	Effective: 12/1/2025 **Updated** policy title **from** "Betaine for Individual and Family Plans" **to** "Metabolic Disorders – Betaine Anhydrous for Individual and Family Plans." • **Added** [documentation required] to indication and to the preferred product table.
Metabolic Disorders – Nitisinone Products - (IP0146)	Updated	Effective: 12/1/2025 **Orfadin (generics) and Nityr:** Alkaptonuria was added as a condition of approval under other uses with supportive evidence**. [Documentation Required]** added to indication.
Multiple Sclerosis and Crohn's Disease (Injectable – Other) – Natalizumab Products Prior Authorization Policy - (IP0690)	Updated	Effective 12/1/2025 Tyruko was added to the policy with the same criteria as Tysabri. The Policy name was changed from "Multiple Sclerosis and Crohn's Disease (Injectable – Other) – Tysabri" to "Multiple Sclerosis and Crohn's Disease (Injectable – Other) – Natalizumab Products". Throughout the policy, wording was changed from Tysabri to natalizumab products (Tysabri, biosimilar).
Nuedexta for Individual and Family Plans - (IP0324)	Updated	Effective: 12/1/2025 **Updated** policy title **from** "Pozelimab-bbfj" **to** "Complement Inhibitors – Veopoz"

		Changed **from** "Pseudobulbar Affect" **to** "Treatment of Pseudobulbar Affect." **Added** [documentation required] to indication.
Neurology – Gene Therapy - Skysona - (IP0529)	Updated	Effective 12/15/25 **Coding Information** **Added** HCPCS: J3397 with a note "Code effective 1/1/2026" **Updated** the description for C9399, J3490 & J3590 to include the note "Code effective until 12/31/2025"
Neurology – Imaavy - (IP0743)	Updated	Effective 12/15/25 Added coding table to the policy with the following: Coding Information: Added HCPCS: J9256 with a code effective date of 1/1/2026
Oncology Medications - (CP1403)	Updated	Effective: 12/1/2025 **Akeega.** **Added** criteria for Akeega for Individual and Family Plan (Effective 1/1/2026) **Avgemsi.** **Added** criteria for Avgemsi (Effective 1/15/2026) **Bosulif.** **Chronic Myeloid Leukemia, Employer Plans** **Updated from** "Trial of, contraindication, or significant intolerance to ONE" **to** " Trial of, contraindication, or significant intolerance to TWO" **Removed** "Patient meets **ONE** of the following: Patient has a history of a serious, chronic lung disease or has had or is at risk of pleural effusion; OR Patient is at risk of bleeding; OR Patient has a prolonged QT interval or is at risk of developing QT interval prolongation **Chronic Myeloid Leukemia, Individual and Family Plans** **Added** criteria for dasatanib as a required alternative **Acute Lymphoblastic Leukemia.** **Added** Criteria for Acute Lymphobastic Leukemia for Employer Plans and Individual and Family Plans **Braftovi.** **Added** criteria for Individual and Family Plan (Effective 1/1/2026)

		Danziten. **Chronic Myeloid Leukemia, Employer Plans** **Removed** ” Patient meets **BOTH** of the following: Patient meets **ONE** of the following: Patient has intermediate- to high-risk chronic phase CML, Patient has accelerated phase CML or blast phase CML; Patient meets **ONE** of the following: Patient has a history of serious, chronic lung disease or has had or is at risk of pleural effusion, Patient is at risk of bleeding **Chronic Myeloid Leukemia, Individual and Family Plan** **Removed** Sprycel as an alternative **Fruzaqla.** **Added** criteria for Fruzaqla for Individual and Family Plans (Effective 1/1/2026) **Iclusig.** **Chronic Myeloid Leukemia, Individual and Family Plan** **Removed** Sprycel as an alternative **Acute Lymphoblastic Leukemia, Individual and Family Plan** **Removed** Sprycel as an alternative **Mektovi.** **Added** criteria for Individual and Family Plans (Effective 1/1/2026) **Nilotinib.** **Chronic Myeloid Leukemia, Individual and Family Plan** **Removed** Sprycel as an alternative **Nilotinib d-tartrate.** **Added** criteria for nilotinib d-tartrate **Onivyde.** **Pancreatic Adenocarcinoma** **Added ”**According to the prescriber, the patient has baseline neuropathy” **Ampullary Adenocarcinoma** **Added ”**According to the prescriber, the patient has baseline neuropathy” **Phyrago.** **Added** criteria for Phyrago for Individual and Family Plans **Revlimid.** **Added** criteria for Revlimid for Employer Plans (Effective 2/1/2026)

		Scemblix **Chronic Myeloid Leukemia, Individual and Family Plan** **Removed** Sprycel as an alternative **Sprycel.** **Added** criteria for Sprycel for Individual and Family Plans **Talzenna.** **Added** criteria for Talzenna for Individual and Family Plans (Effective 1/1/2026) **Tasigna.** **Chronic Myeloid Leukemia, Individual and Family Plan** **Removed** Sprycel as an alternative
Ophthalmology – Gene Therapy - Encelto - (IP0744)	Updated	Effective: 11/20/2025 **Updated** Policy Statement **Macular Telangiectasia Type 2, Idiopathic:** Policy intent was to approve one implant per affected eye(s); revised verbiage and clarified intent. In addition, a requirement that patient is not receiving re-treatment of eye(s) previously treated with Encelto was added. **Conditions Not Recommended for Approval:** Re-treatment of previously treated eye(s) was added. **Updated** policy template.
Papillomatosis-Gene Therapy Papzimeos - (IP0765)v	New	Effective: 12/1/2025 • New coverage policy. • Coding Information: • Added HCPCS: C9399, J3490 & J3590
Pharmacy and Medical Prior Authorization - (1407)	Updated	Effective: 12/1/2025 **Added Individual and Family Plan product-specific medical necessity criteria for the following products:** Seysara, Cleocin Vaginal Ovules, Nuvessa, Xaciato, Conjupri,

		levamlodipine tablets, Novolin 70/30 FlexPen and vials, Novolin N FlexPen and vials, Novolin R FlexPen and vials, Novolog Mix 70/30 FlexPen and vials, Estring, Gloperba, Fosrenol oral powder, Fosrenol chewable tablets, lanthanum carbonate chewable tablets, Renvela oral powder, sevelamer carbonate powder for oral suspension, sevelamer hydrochloride tablet (authorized generic for Renagel), Velphoro, Spiriva HandiHaler, tiotropium bromide inhalation powder (generic for Spiriva HandiHaler), Spiriva Respimat, Yupelri, doxepin 3 mg and 6 mg tablets (Silenor authorized generic), Edluar, Silenor, zolpidem 7.5 mg capsules (brand), zolpidem 1.75 mg and 3.5 mg sublingual tablet (generic for Intermezzo), Belsomra, Dayvigo, Quviviq, and sertraline 150 mg and 200 mg capsules. • **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** insulin aspart protamine/insulin aspart, Flexpen and vials (authorized generic of Novolog Mix 70/30), Femring, Imvexxy, Premarin Vaginal Cream, and Osphena.
Pharmacy and Medical Prior Authorization - (1407)	Updated	Effective: 12/15/2025 **Added Individual and Family Plan product-specific medical necessity criteria for the following products:** Tolak, butalbital 50 mg/acetaminophen 325 mg/caffeine 40 mg per 15 mL oral solution, Norgesic (effective 1/1/2026), Norgesic Forte (effective 1/1/2026), orphenadrine/aspirin/caffeine 25-385-30 mg tablets (generic for Norgesic) (effective 1/1/2026), orphenadrine/aspirin/caffeine 50-770-60 mg tablet (generic for Norgesic Forte) (effective 1/1/2026), Orphengesic Forte (effective 1/1/2026), Blujepa, Dificid, fidaxomicin tablets (generic for Dificid), fosfomycin granules for solution, Orlynvah, econazole nitrate foam, eslicarbazepine acetate tablets (generic for Aptiom), perampanel tablets (generic for Fycompa tablets), Kloxxado, Zurnai, Zimhi, Motegrity, Analpram-HC lotion, Brynovin, Kirsty, Kirsty Pen, Brekiya, Trudhesa, Amrix, chlorzoxazone 250 mg, 375 mg, and 750 mg tablet, Lorzone, methocarbamol 1000 mg tablet, baclofen oral suspension, concentrated formulation 25 mg/5mL (Fleqsuvy generic), Fleqsuvy, Lyvispah, Ozobax, Ozobax DS, and Pruradik. **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** Carac, Klisyri, Aplenzin, Opvee, prucalopride 1 mg, 2 mg oral tablets (generic for Motegrity), and baclofen 5 mg/5 mL oral solution (Ozobax generic)
Phenylketonuria – Sapropterin - (IP0295)	Updated	Effective: 12/1/2025 Zelvysia was added to the policy with the same criteria as existing sapropterin products.

		• **Preferred Product Table: Added** Zelvysia **to** table for Individual and Family Plans.
Pheochromocytoma-Metyrosine and Phenoxybenzamine (Oral) - (IP0450)	Updated	Effective: 12/1/2025 **Policy Title:** **Updated** from "Metyrosine" to "Pheochromocytoma-Metyrosine and Phenoxybenzamine (Oral)." **Added** Preferred Product Criteria Table for brand use of Demser to coverage policy. **Added** Dibenzyline criteria for Individual and Family Plan Benefit Plans to coverage policy.
Pulmonary Arterial Hypertension and Related Lung Disease – Inhaled Prostacyclin Products - (IP0753)	Updated	Effective 12/15/2025 Ventavis was removed from the policy.
Pulmonary Arterial Hypertension – Epoprostenol Products - (IP0762)	Updated	Effective: 12/1/2025 ○ **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1]:** For initial therapy, Orenitram (treprostinil extended-release tablets), and Uptravi (selexipag tablets) were removed from the Note of examples of oral medications that the patient has tried or is currently receiving for the condition in Functional Class II.
Pulmonary Arterial Hypertension – Treprostinil Injection PA - (IP0757)	Updated	Effective: 12/1/2025 **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1]:** For initial therapy, Orenitram (treprostinil extended-release tablets), and Uptravi (selexipag tablets) were removed from the Note of examples of oral medications that the patient has tried or is currently receiving for the condition in Functional Class II.
Sohonos - (IP0596)	Updated	Effective: 12/15/2025 **Policy Title**: **Updated from** "Palovarotene" **to** "Sohonos"

		Updated policy template. **Fibrodysplasia ossificans progressive:** **Added** an asterisk (*) next to "female" and "male" to reference gender definitions in the policy statement. **Updated** criterion **from** "Genetic test confirming an R206H pathogenic variant in ACVR1 (ALK2) consistent with a diagnosis of fibrodysplasia ossificans progressive" **to** "Patient has had a genetic test confirming a pathogenic variant in Activin A Type 1 Receptor (ACVR1)^{R206H} consistent with a diagnosis of fibrodysplasia ossificans progressiva **[documentation required]**." **Moved** examples of radiologic testing to a "Note"
Somatostatin Analogs – Mycapssa (IP0491)	Updated	Effective 12/15/2025 **Policy Title: Updated from** "Mycapssa" **to** "Somatostatin Analogs – Mycapssa" Acromegaly **Updated from** "Documentation of a pretreatment insulin-like growth factor 1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory" **to** "Patient has (or had) a pretreatment (baseline) insulin-like growth factor 1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory" **Added** Note: Pretreatment (baseline) refers to the IGF-1 level prior to the initiation of a somatostatin analog (e.g., Mycapssa [octreotide delayed-release capsules], an octreotide acetate injection product [e.g., Bynfezia Pen, Sandostatin {generic}, Sandostatin LAR Depot], Signifor LAR [pasireotide injection], Somatuline Depot [lanreotide injection], dopamine agonist [e.g., cabergoline, bromocriptine], or Somavert [pegvisomant injection]). Reference ranges for IGF-1 vary among laboratories. **Updated from** "Documentation that the individual has responded to one octreotide acetate injection product or Somatuline Depot (lanreotide injection)" **to** "According to the prescriber, patient has responded to one octreotide acetate injection product or Somatuline Depot (lanreotide injection)" **Employer Plans and Individual and Family Plans** **Updated** preferred product criteria
Spinal Muscular Atrophy – Gene	Updated	Effective: 12/1/2025 • **Spinal Muscular Atrophy – Treatment:** The requirement was removed which stated that according to the prescribing physician, the patient has started or will receive

Therapy – Zolgensma - (IP0185)		systemic corticosteroids equivalent to oral prednisolone at a dose of 1 mg/kg per day commencing 1 day prior to Zolgensma infusion and for a total of 30 days. Also, regarding the requirement that addresses Evrysdi, it was added that the agent is now available in tablets.
Testosterone (Injectable) Products - (IP0351)	Updated	Effective 12/15/2025 **Coding Information:** **Added HCPCS:** J1072 **Added HCPCS:** J1073 with a note "Code effective 1/1/2026" **Updated** the description for S0189 to include the note "Code effective until 12/31/2025"
Topical Diclofenac Sodium 3% Gel - (IP0282)	Updated	Effective: 12/15/2025 **Added** FDA Approved Indications for "Actinic Keratosis," "Actinic Cheilitis," and "Disseminated Superfiical Actinic Porokeratosis" to policy. **Updated** Preferred Product Table to show standard format and updated language, and split them into Employer Plans and Individual and Family Plans. **Removed** "Disseminated Superficial Actinic Porokeratosis" criteria **from** Preferred Product Tables.
Topical Retinoids – Aklief - (IP0180)	Updated	Effective: 12/1/2025 **Policy Statement:** The following was added "Prescription benefit coverage is excluded for cosmetic uses." **Conditions Not Recommended for Approval**: Treatment of cosmetic conditions was added. **Added [documentation required] to** preferred product tables for Employer Plans and Individual and Family Plans.
Topical Tazarotene Products - (IP0174)	Updated	Effective: 12/15/2025 **Policy Title.** **Updated from** "Topical Tazarotene Products" **to** "Topical Retinoids – Tazarotene Products"

		Acne Vulgaris. **Added** "Approve for 1 year when the following criteria is met: Preferred product criteria are met for the products listed in the below table(s)" **Plaque Psoriasis.** **Added** "Approve for 1 year when the following criteria is met: Preferred product criteria are met for the products listed in the below table(s)" **Treatment of Other Non-Cosmetic Conditions.** **Added** "Approve for 1 year when the following criteria is met: Preferred product criteria are met for the products listed in the below table(s) Note: Examples of other non-cosmetic conditions include: acne keloidalis nuchae, basal cell carcinoma, comedonal acne, cystic acne, cutaneous T-cell lymphoma, ichthyosis (e.g., congenital, lamellar, vulgaris, X-linked), keratoderma blennorrhagicum, keratosis (e.g., keratosis follicularis [Darier's disease], keratosis pilaris), mycosis fungoides, nail psoriasis, oral lichen planus, and warts." **Preferred Product Table.** **Updated** table to match the Formulary Exception File. • **Removed** Tazorac 0.05% cream, 0.1% cream, 0.05% gel, and 0.1% gel from Employer Plans.
Xiaflex - (IP0143)	Updated	Effective: 12/1/2025 **Policy Title:** **Updated from** "Collagenase Clostridium Histolyticum" **to** "Xiaflex" **Dupuytren's Contracture:** **Updated** authorization **from** "up to a maximum of three injections per cord" **to** "approve Xiaflex for 3 months if…" **Updated** criterion **from** "Treatment of symptomatic Dupuytren's contracture with presence of a palpable cord" **to** "Patient has at least one palpable cord in the affected hand." **Updated** criterion **from** "Treatment of symptomatic Dupuytren's contracture with functional impairment as manifested by a metacarpophalangeal (MCP) joint or proximal interphalangeal (PIP) joint contracture of 20 degrees or greater at baseline (prior to initial injection of Xiaflex)" **to** "Patient has a contracture of a metacarpophalangeal or proximal interphalangeal joint that is associated with the palpable cord AND at baseline (prior to initial injection of Xiaflex), the contracture measures at least of 20 degrees."

		Updated criterion **from** "As part of the current treatment course, the individual will NOT be treated with more than a total of three injections (maximum) per affected cord" **to** "As part of the current treatment course, the patient will be treated with up to three injections (maximum) per affected cord" **Peyronie's Disease:** **Updated** authorization **from** "up to a maximum of 4 treatment cycles (or 8 injections) per Peyronie's plaque" to "approve Xiaflex for 6 months…" **Updated** criterion **from** "Presence of a palpable plaque" **to** "Patient has at least one palpable plaque in the penis." **Updated** criterion **from** "Will NOT be treated with more than a total of 8 injections (maximum) per Peyronie's plaque" **to** "Patient has not previously been treated with a complete course (8 injections) for Peyronie's disease." **Dosing: Added** "Note: For a patient who has already received one or more injections of Xiaflex, approve the duration requested up to the amount needed to complete one course of therapy (e.g., a patient who has received 3 injections may be approved for 5 additional injections to complete one course of therapy)." **Conditions Not Covered** **Cosmetic Use:** **Updated** to add "Cosmetic use is not recommended for coverage as this indication is excluded from coverage in a typical medical benefit" **Removed** "cellulite of buttocks" as an example of cosmetic use and **added** "Note: An example of cosmetic use includes cellulite treatment."
Wakefulness-Promoting Agents – Armodafinil, Modafinil - (IP0075)	Updated	Effective 12/1/2025 • **Excessive Daytime Sleepiness Associated with Obstructive Sleep Apnea:** Removed "Hypopnea Syndrome" from the approval condition.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 30 - (IP0206)	Updated	Effective 12/15/2025 Liraglutide, generic to Saxenda was added to the policy. **Policy Statement**: The following was added: In clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression; females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression. Because of the specialized skills required for evaluation and diagnosis of patients

		treated with Wegovy as well as the monitoring required for adverse events and long-term efficacy, approval requires Wegovy to be prescribed by or in consultation with a physician who specializes in the condition being treated. The Policy Statement was updated as follows to address the availability of liraglutide, generic to Saxenda: Prior Authorization is recommended for prescription benefit coverage of liraglutide (Saxenda, generic), Wegovy, and Zepbound. Of note, this policy targets liraglutide (Saxenda, generic), Wegovy, and Zepbound; other glucagon-like peptide-1 agonists that do not carry an FDA-approved indication for weight loss are not targeted in this policy. **Documentation:** A requirement for documentation was added for the use of Wegovy for MASH. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. Wegovy: **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).** A new condition of coverage was added to FDA-Approved Indications. Conditions Not Recommended for Approval: **Concomitant Use with Other Medications FDA-Approved for Weight Loss.** This condition not recommended for approval was removed. Liraglutide (Saxenda, generic), Wegovy, and Zepbound: **Weight Loss in an Adult with Overweight or Obesity:** Initial Therapy and Patient is Continuing on Therapy: The notes that define baseline were updated to include liraglutide, generic to Saxenda. Liraglutide (Saxenda, generic) and Wegovy: **Weight Loss in a Pediatric Patient with Obesity:** Initial Therapy and Patient is Continuing on Therapy: The notes that define baseline were updated to include liraglutide, generic to Saxenda. Saxenda **Weight Loss in an Adult with Obesity or is Overweight.** Initial therapy **Added** preferred product requirements. **Weight Loss in a Pediatric Patient with Obesity.**

		Initial therapy **Added** preferred product requirements.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 32 - (IP0621)	Updated	Effective 12/15/2025 Liraglutide, generic to Saxenda was added to the policy. Conditions Not Recommended for Approval: **Concomitant Use with Other Medications FDA-Approved for Weight Loss.** This condition not recommended for approval was removed. Liraglutide (Saxenda, generic), Wegovy, and Zepbound: **Weight Loss in an Adult with Overweight or Obesity:** Initial Therapy and Patient is Continuing on Therapy: The notes that define baseline were updated to include liraglutide, generic to Saxenda. Liraglutide (Saxenda, generic) and Wegovy: **Weight Loss in a Pediatric Patient with Obesity:** Initial Therapy and Patient is Continuing on Therapy: The notes that define baseline were updated to include liraglutide, generic to Saxenda. Saxenda **Weight Loss in an Adult with Obesity or is Overweight.** Initial therapy **Added** preferred product requirements. **Weight Loss in a Pediatric Patient with Obesity.** Initial therapy **Added** preferred product requirements. **Policy Statement:** The following was added: In the clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression; females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression. Because of the specialized skills required for evaluation and diagnosis of patients treated with Wegovy for MASH/NASH as well as the monitoring required for adverse events and long-term efficacy, approval requires Wegovy for MASH/NASH to be prescribed by or in consultation with a physician who specializes in the condition being treated.

		Wegovy: **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).** A new condition of approval was added to FDA-Approved Indications.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 35 - (IP0739)	Updated	Effective 12/15/2025 Liraglutide, generic to Saxenda was added to the policy. **Policy Statement**: The following was added: In clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression; females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression. Because of the specialized skills required for evaluation and diagnosis of patients treated with Wegovy as well as the monitoring required for adverse events and long-term efficacy, approval requires Wegovy to be prescribed by or in consultation with a physician who specializes in the condition being treated. The Policy Statement was updated as follows to address the availability of liraglutide, generic to Saxenda: Prior Authorization is recommended for prescription benefit coverage of liraglutide (Saxenda, generic), Wegovy, and Zepbound. Of note, this policy targets liraglutide (Saxenda, generic), Wegovy, and Zepbound; other glucagon-like peptide-1 agonists that do not carry an FDA-approved indication for weight loss are not targeted in this policy. **Documentation:** A requirement for documentation was added for the use of Wegovy for MASH. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. Wegovy: **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).** A new condition of coverage was added to FDA-Approved Indications. Conditions Not Recommended for Approval: **Concomitant Use with Other Medications FDA-Approved for Weight Loss.** This condition not recommended for approval was removed.

		Liraglutide (Saxenda, generic), Wegovy, and Zepbound: **Weight Loss in an Adult with Overweight or Obesity:** Initial Therapy and Patient is Continuing on Therapy: The notes that define baseline were updated to include liraglutide, generic to Saxenda. Liraglutide (Saxenda, generic) and Wegovy: **Weight Loss in a Pediatric Patient with Obesity:** Initial Therapy and Patient is Continuing on Therapy: The notes that define baseline were updated to include liraglutide, generic to Saxenda. Saxenda **Weight Loss in an Adult with Obesity or is Overweight.** Initial therapy **Added** preferred product requirements. **Weight Loss in a Pediatric Patient with Obesity.** Initial therapy **Added** preferred product requirements.
Cardiology – Zontivity for Individual and Family Plans - (IP0707)	Updated	Effective: 12/1/2025 • No change in coverage.
Niemann-Pick disease type C – Aqneursa - (IP0715)	Updated	Effective: 12/15/2025 • No criteria changes.
Niemann-Pick disease type C – Miplyffa - (IP0716)	Updated	Effective: 12/15/2025 • No criteria changes.
Ophthalmology – Upneeq - (IP0088)	Updated	Effective 12/15/2025 • No criteria changes.

Parkinson's Disease – Vyalev - (IP0717)	Updated	Effective 12/15/2025 • No criteria changes
Sickle Cell Disease – Oxbryta - (IP0119)	Updated	Effective: 12/15/2025 • No criteria changes.
Colchicine Oral Solution - (IP0268)	Retired	Effective 12/1/2025
Gabapentin Extended-Release (IP0317)	Retired	Effective 12/15/2025
Long-Acting Muscarinic Antagonists (Nebulized) - (IP0089)	Retired	Effective 12/1/2025
Prucalopride - (IP0017)	Retired	Effective 12/15/2025
Sarecycline - (IP0093)	Retired	Effective 12/1/2025
Sedative Hypnotic Medications - (IP0023)	Retired	Effective 12/1/2025
Sertraline 150 mg, 200 mg Oral Capsules - (IP0328)	Retired	Effective 12/1/2025
Skeletal Muscle Relaxants - (IP0211)	Retired	Effective 12/15/2025

Vaginal Estrogen Products and Ospemifine - (IP0216)	Retired	Effective 12/1/2025
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Precertification Policies	Updates	Updated prior authorization requirements are available on our websites, CignaforHCP.com and Cigna.com. Updates include existing codes that have been removed from prior authorization. **Updates:** For December 30, 2025, 9 CPT and 4 HCPCS codes were removed from prior authorization.
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Physician Interpretation and Report (I&R) Services - (R26)	Updated	
Newborn Inpatient Level of Care Billing Guidelines - (R29)	Updated	
Dialysis Services and Supplies - (R16))	Updated	
Diagnosis Coding Guidelinesv - (R47)	Updated	
Procedure and Place of Service - (R43)	Updated	

Other Coding and Reimbursement Documents	New, Updated, or Retired?	Comments
		• No updates for December 2025
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
		• No updates for December 2025